Cost and Quality Conversation

PRACTICE SELF-ASSESSMENT

Please select all of the items that are true for your practice:

☐ Has Team Huddles	☐ Uses patient-centered decision support tools	☐ Considers social determinants when determining treatment options (ie age, gender, work setting, living arrangements, etc)
☐ Practices Team-Based Care	☐ Uses paper education tools for patients	☐ Provides multiple treatments options to the patient (when multiple options exist)
☐ Has Team Meetings Regularly	☐ Uses online education tools for patients	☐ Conducts Pre-Visit Planning
☐ Explores medication adherence issues	☐ Follows up with patients who have not gotten a lab, test or imaging service as ordered	☐ Has a champion for Quality Improvement Initiatives
☐ Engages patients in medication adherence discussions	☐ Is aware of community resources where patients can learn more about cost/quality information	☐ Has tried Quality Improvement initiatives
☐ Engages the patient in treatment planning	☐ Has a patient educator on staff	
☐ Asks if medications are taken as prescribed	☐ Has a care coordinator on staff	

These items are indicative of a workflow that incorporates elements that support constructive cost/quality conversations with patients. The more items checked off, the more prepared you are for successfully integrating the conversation in your workflow! If there are items that you don't incorporate, but are interested in learning more about, please use the following resources:

ACP Practice Advisor

ACP High Value Care Courses

AHRQ Shared Decision Making Toolkit

AMA Steps Forward

Select the measures that your practice currently pursues or plans to pursue for each Quality Initiative:

MIPS Improvement Activities	
☐ IA_PM_11 Population Management (Medium): Regular Review Practices in Place on Targeted Patient Population Needs	
☐ IA_CC_9 Care Coordination (Medium): Implementation of practices/processes for developing regular individual care plans	
☐ IA_BE_15 Beneficiary Engagement (Medium): Engagement of Patients, Family, and Caregivers in Developing a Plan of Care	
☐ IA_PSPA_20 Patient Safety and Practice Assessment (Medium): Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	
NYS PCMH	
Core	**Elective**
☐ CC 01 A,B: Lab and Imaging Test Management	☐ CC 13: Treatment Options and Costs: Engages with Patients regarding cost implications of Treatment options
☐ CC 04: Tracking referrals until the report is available, flagging and following up on overdue results.	☐ CM 07: Identifies and discusses potential barriers to meeting goals in individual care plans
☐ QI 04: Patient Experience Feedback	☐ CC 07: Performance information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals
CPC+	
Track 1	
☐ Function 3, Requirement 3.1: Systematically identify high volume and/or high-cost specialists serving the patient population using CMS/other payers' data.	☐ Function 4, Requirement 4.1: Convene a PFAC at least three times in PY 2 and integrate recommendations into care and quality improvement activities, as appropriate.
Track 2	
☐ Function 2, Requirement 2.3: For patients receiving longitudinal care management, use a plan of care containing at least patients' goals, needs, and self-management activities that can be routinely accessed and updated by the care team.	☐ Function 2, Requirement 2.6: Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.
☐ Function 3, Requirement 3.1: Systematically identify high volume and/or high-cost specialists serving the patient population using CMS/other payers' data.	☐ Function 3, Requirement 3.3: Enact collaborative care agreements with at least two groups of specialists, identified based on analysis of CMS/other payer reports.
☐ Function 3, Requirement 3.5: Systematically assess patients' psychosocial needs using evidence-based tools.	☐ Function 3, Requirement 3.6: Conduct an inventory of resources and supports to meet patients' psychosocial needs.
TCPI	
☐ PFE Measure 2, Shared Decision Making	

Congratulations on your efforts! Each of these quality initiative measures directly relates to or supports the quality and cost of care conversation with your patients. By already participating, you are well on your way to starting constructive conversations. This may also help you to determine which measures to pursue if they were not already chosen.

Examine the current steps in the practice's workflow. At each step of a patient's visit, who is involved and what are their responsibilities?

TIMING	ROLE NAME/ CREDENTIALS	CURRENT RESPONSIBILITIES
PRE-VISIT PLANNING		
CHECK-IN		
ROOMING/TRIAGE		
VISIT		
CHECK-OUT		
AFTER-VISIT CARE		

In the first step to sustainable change, stakeholders need to understand why and how they can help. Now that you have outlined the roles and responsibilities involved in a patient visit, look at the patient-touch points. Each is an opportunity to engage with and empower the patient. Formulate ideas on the best touch points, roles to be responsible for engaging the patient, and a general idea of how they will engage the patient. Then, present these findings and ideas at your team meeting to elicit feedback. This will reinforce the goals of the change, provide a better understanding for stakeholders and also help to prepare for training. Stakeholder feedback will help to identify possible gaps as well as gather ideas. They will be engaged in the change and prepared for the next step!